University of Alberta

THE NATURE OF CARING IN NURSE-TO-NURSE RELATIONSHIPS

by

Linda Diane MacKay ©

A Thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Nursing

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ABSTRACT

There is widespread recognition among researchers that caring is central to the work that nurses do with, and for, patients. As human beings, nurses have the same caring needs as others. The purpose of this study is to explore if, and how, nurses are cared for by their colleagues and the impact on nurses if caring occurs. An exploratory descriptive design was chosen to answer the research question. Several themes emerged, including: the essence of caring in nurse-to-nurse relationships, what facilitates or blocks collegial caring interactions, the differences in nurse-to-nurse caring compared to nurse-to-patient caring, the impact of nurse-to-nurse caring, and evidence of an apparent process of caring. It is concluded that sensitivity combined with a desire to care for nursing colleagues is the basis of nurse-to-nurse caring. The findings suggest that intercollegial nurse caring needs to be valued to facilitate future nurse-to-nurse caring.

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Thesis Overview

The research described in this document relates to the nature of caring in nurse-to-nurse relationships. This thesis consists of an overview, two manuscripts, and a postscript. The first manuscript is a review of the literature that served as a background for the study. The second manuscript is a summary of the research written as an article for submission to a journal. The postscript is a reflection of the methods used during the research.

Background

This study began with a review of the literature on nursing and caring. The literature selected for this review consisted of studies of patients' and nurses' perceptions of caring and conceptualizations of caring. Most of these studies focused on nurse-to-patient relationships and often revealed differences between patients' and nurses' perceptions of caring. A major gap in the literature was the absence of research into nurse-to-nurse caring, and this led to the decision to undertake this study.

The essence of nursing is to care for others but it seems clear from the literature that nurses often do not care for themselves (Reverby, 1987). The profession of nursing is carried on in environments that are often demanding and rigid, while the work of nurses is said to be invisible and undervalued. These environments create a need for nurses to be cared for and replenished so that they can in turn continue to care for patients. There is evidence in the literature to suggest that nurses value and need the caring and support of their colleagues. The results of this study are expected to provide some preliminary insights into the phenomenon of nurse-to-nurse caring.

The term caring, while used extensively in the literature, is often confusing and not well understood. Some authors refer to caring as actions of nursing while others refer to caring as a way of being. Gadow (1989), Leininger (1986, 1988), Noddings (1984) and Watson (1988) state that caring evolves from interpersonal relationships and has positive results. This need to clarify the meaning of caring and examine the nature of collegial

caring led to this study.

The second manuscript is a report of the research carried out on the nature of caring in nurse-to-nurse relationships written in the form of a journal article. The objectives of this study were to examine:

- If nurses experience caring behaviours from their peers.
- Under what conditions nurses care for their peers.
- If being cared for by peers is important to nurses.
- To what extent feeling cared for helps nurses fulfill their obligations to patients.

Seven nurses were identified by their colleagues as caring nurses and these nurses were interviewed in order to gain an understanding of the nature of caring in nurse-to-nurse relationships.

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Caring: A Review of the Literature

The phenomenon of caring is complex, obscure, and has diverse meaning to people in different settings (Bevis, 1981; Kurtz & Wang, 1991; Kyle, 1995; Mayeroff, 1971; Shiber & Larson, 1991; Watson, 1979). The objective of this paper is to describe conceptualizations of caring, to examine the existing caring research, and to explore the need for caring in nurse-to-nurse relationships. The literature review is organized around four main content areas: contemporary conceptualizations of caring, patients' perceptions of caring, nurses' perceptions of caring, and the need for caring in nurse-to-nurse relationships.

Conceptualizations of Caring

Some philosophers conceive of caring as an integral part of existence because, as Mayeroff (1971) suggests, caring promotes growth and actualization in others. Heidegger (1977) believed that if humans exist, then humans care. In his view, caring is an essential component of being.

Gaylin (1976) maintains that caring is critical to the survival of humans. In the face of atrocities such as those seen during the holocaust, human beings were treated like objects; their development was halted and many did not survive. Evidence suggests that people in these situations continued to care for each other, even in the face of certain death (Koren, 1988). Indeed, for many, it was the caring that gave them the courage to continue.

Caring, as a concept, has been defined and conceptualized in various ways. It has been identified as the essence of nursing, the core of nursing, and a paradigm unique to nursing (Cohen, 1991; Leininger, 1986; Roach, 1987; Watson, 1988). Leininger (1986) discusses caring in a cultural context, while Cohen (1991) and Watson (1988) discuss caring in a spiritual context. All three, however, identify caring as the central theme of nursing science. Morse, Solberg, Neander, Bottorff, and Johnson (1990) note that caring results in a subjective experience and is categorized in five different ways. These

categories include caring as: a human state, a moral imperative or ideal, an affect, an interpersonal relationship, and a nursing intervention. Caring is central to these differing categories and is based on ideal, human, interpersonal relationships evident in nursing interventions.

Gadow (1989), Leininger (1986, 1988), and Watson (1988) assert that caring evolves from an interpersonal relationship and is unique to that relationship. Establishing trust, and comfort in a safe, non judgmental, supportive social context and developing an interconnectedness between people, facilitates the achievement of caring (Watson, 1990; Wolf, Giardina, Osborne, & Ambrose, 1994). Watson (1979) proposes that caring is a process whereby the person caring becomes responsible for another human being, discerns the other's feelings, and then sets that human apart from the ordinary. Similarly, Gadow (1989) suggests that caring, practiced as part of a relational narrative, produces shared meanings for the one caring and the one cared for. Growth, change, and actualization for both participants results from caring behaviours that occur through the interpersonal process (Bevis, 1981; Leininger, 1986; Mayeroff, 1971; Shiber & Larson, 1991). Noddings (1984) states that, "Apprehending the other's reality, feeling what he feels as nearly as possible, is the essential part of caring from the view of the one caring" (p.74). The proposition that nurse caring occurs within a relational context is increasingly being favoured, for, as Ray (1994) states, "Nursing is a relational caring process" (p.26). Maeve (1994) corroborates this perspective when she states, "Nursing identity lies in relationship" (p.13). Effective communication, shown by listening and effective interpersonal skills, is necessary to achieve caring (Buoneristian, 1990; Larson, 1986, 1987; Mayer, 1986; Noddings, 1984). Valuing the person as unique, and thus showing respect, stands as an underlying principle for all caring transactions (Cronin & Harrison, 1988; Gaut, 1986; Griffin, 1983; Hicks, 1990; Kahn & Steeves, 1988; Swanson, 1991).

Caring is viewed as positive when it is perceived as central and unifying to human beings and critical to human growth, development, and ultimate survival (Bottorff &

D'Cruz, 1984; Gaylin, 1976; Leininger, 1986; Mayeroff, 1971; O'Berle & Davies, 1992). Caring can result in improved human relationships, increased motivation, and expanded energy (Bevis, 1981). Caring for colleagues could result in a work environment that provides better care and caring for patients. Benner (1984) describes the healing relationship between the person caring and the person cared for; she suggests that a climate is created where a commitment to healing is developed. According to Noddings (1984) when human beings care for one another, both the person caring and the person cared for benefit, grow, and feel valued.

Patients' Perceptions of Caring

The vast majority of studies reviewed focused on patients' perceptions of caring and nurses' perceptions of caring in nurse-to-patient relationships, rather than on nurse-to-nurse relationships. One of the major themes to emerge from the research is the acknowledgement of the importance of the individual patient's perception of caring. This acknowledgement supports the contention of Gadow (1989, 1994), Leininger (1986), and Watson (1988) that caring evolves from an interpersonal relationship and is unique to that relationship. In a qualitative study by Brown (1986), 50 patients said they felt cared for when nurses recognized them as unique human beings, provided a reassuring presence, gave pertinent information, and assisted with pain relief. Larson (1984) studied 57 patients with cancer who said that for them, nurse caring behaviours included anticipating, comforting, explaining, facilitating, and developing and sustaining trusting relationships. Similarly, when interviewing 12 randomly chosen acute care patients, Paternoster (1988) noted that patients felt cared for when their needs were recognized and acted upon. In a phenomenological study of 20 married women who had miscarried, Swanson (1986) referred to nurse caring behaviour as knowing the patient. Conversely, in a 1990 phenomenological study of care provision in a neonatal intensive care unit, Swanson stated that, "An important part of responsible management of care is to avoid becoming too attached - a bad outcome of caring too much" (p.70). This creates

confusion for nurses attempting to understand the importance of a relationship to true caring. In descriptions of caring and non-caring in the clinical setting, Johnston Reiman (1986) provides an example of non-caring when she tells of a patient being treated as an unvalued object. This example of non-caring enhances our understanding of the caring concept under discussion because, by clarifying in our minds the opposite concept, we are better able to clearly grasp the concept we seek to understand. The majority of these studies show that from the patient's perspective it is important to enter into a relationship with the patient and value the patient.

One theme that appears in many studies is the involvement of time in caring. Brown (1986) refers to the amount of time spent as indicative of caring, while Mayer (1986) talks about allowing time for patients to fully express their feelings. Swanson (1986) discusses the actions "of doing for" that take time. As well, the development of an interpersonal relationship takes time (Gadow, 1989). Johnston Reiman (1986) talks about being in a hurry and being efficient as attributes that can be viewed as non-caring. Studies involving patient responses to caring indicate that patients have an increased sense of well-being, increased comfort, and a sense of being valued which assist in the healing process when caring occurs (Paternoster, 1988; Johnston Reiman, 1986).

Nurses' Perceptions of Caring

Ten studies of caring from a nurse perspective relate to the concept of a relational interaction between the nurse and the patient. (Bottorff, 1991; Bottorff & D'Cruz, 1984; Dyson, 1996; Ford, 1990; Forrest, 1989; Kahn & Steeves, 1988; Larson, 1986; Leininger, 1986; Morrison, 1991; Swanson, 1990; Wolf, 1986). Each of these studies reflects Gadow's (1989) relational narrative and Watson's (1988) interpersonal relationship. For example, Bottorff and D'Cruz (1984) suggest nurse caring can be ideally accomplished in a context of social relational involvement. Knowing the patient well has been identified as integral to caring by nurses (Ford, 1990; Forest, 1989; Larson, 1986; Swanson, 1990) as well as having sensitivity, empathy, and compassion (Dyson, 1996; Kahn & Steeves,

1988; Leininger, 1988; Wolf, 1986). All these terms reflect Leininger's attachment stage of caring, as well as Gadow's and Watson's notion of the development of a relational, or interpersonal interaction. In conclusion, while caring can be accomplished in many ways, the development of a relationship enhances caring.

The Need for Caring in Nurse-to-Nurse Relationships

Women's work, with which caring is associated, is undervalued and underpaid (Benner & Wrubel, 1989; Bottorff & D'Cruz, 1984; Watson, 1990). Since most nurses are women, the role and status of nurses tend to reflect the role and status of women generally. Indeed exploring the meaning of the concept of caring from a nursing perspective, Kurtz & Wang (1991) state that major societal values are sometimes incongruent with the value of caring. Further, Reverby (1987) contends that nursing is part of a profession ordered to care by a society that refuses to value caring, and to care within a system with rigid rules and protocols.

The majority of nurses today work in hospitals or institutional settings, environments where efficiency and a focus on technology are valued. Hospitals are complex bureaucracies and nurses occupy a central role in their socio-technical systems. An inflexible organizational structure can impede the essence of caring as many nurses believe that caring takes time and works best in a responsive environment. Moreover, much of the work of nurses is invisible and not amenable to objective quantification and, according to Jacques (1993), is therefore not regarded as expertise. Additionally, nurses are subject to many incompatible demands from physicians, patients, and administrators which often lead to job dissatisfaction, stress, and burnout (Roberts, 1983).

Hospitals are increasingly under economic pressure to become more and more efficient while costs continue to rise. Allocation of funding is contingent on classification systems that are based on easily measured tasks and high work loads, rather than on the process of caring; this results in anxiety and stress for the individual nurse who values caring (Holden, 1991; Morrison, 1989; Paternoster, 1988; Watson, 1990). Nurses

sometimes provide caring to their patients in settings where they themselves are not cared for by their organizations, by their employers, or by their colleagues (Reverby, 1987).

Benner (1984) states that "the demands of nursing are large ones. The pains, risks, and dangers encountered are sometimes great and cannot be experienced without personal cost" (p. 208). Nurses become estranged from one another as they are primarily composed of women engaged in undervalued work; this can result in helplessness and oppression (Keen, 1991). Oppression is defined as an unjust or cruel exercise of authority or power (Guralnik, 1979). It is difficult in nursing practice to be caring of others when experiencing oppression; people who are oppressed often strike out against each other rather than support, value, or care for one another (Roberts, 1983).

Although caring has been studied increasingly over the past decade, in the majority of studies, caring has been examined in relation to nurse-patient interactions or human-to-human caring. No studies have been located with respect to caring in nurse-to-nurse relationships. Little is known about the importance nurses attach to caring for each other. For example, do nurses experience caring behaviour from their peers? Under what conditions do they care for their peers? How important is it for nurses that they be cared for by their peers? To what extent does feeling cared for help nurses to fulfill their obligations to patients? There is evidence to suggest that caring among colleagues is important and valued. It may be a central element of being supportive of each other. If this premise is correct, then there are implications for nurses, nurse educators, and nurse administrators. Nurse-to-nurse caring should be recognized, valued, and promoted in settings where nurses work.

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The Nature of Caring in Nurse-to-Nurse Relationships

Caring is widely assumed to be central to nurses' work in relation to patients and its analysis has become increasingly more important as nurses strive to differentiate the work of nurses from that of other health professionals (Bevis, 1981; Bottorff, 1991; Leininger, 1981a, 1981b, 1986, 1988; Watson, 1979, 1988). Although much has been written about the caring aspects of nurse-to-patient interactions over the past two decades (Benner, 1984; Benner & Wrubel, 1989; Leininger, 1981a, 1981b; Watson, 1979, 1988), only peripheral attention has been directed towards nurse-to-nurse relationships. It is logical to assume that nurses have caring needs which must be met in order to replenish the energy expended in caring for patients (Watson, 1979). Nurses have identified supportive colleagues as an important aspect of the quality of their work life (Attridge & Callahan, 1990). If research into the nature of caring between nurses can contribute to a better understanding of collegial support, this may improve nurses' work life and enhance nursing practice.

Literature Review

Nursing is a relational profession in which caring is central to the work of nurses (Watson, 1979). Benner, Tanner, and Chesla (1996) believe that knowledge about caring is acquired as a result of dialogue and relationships. The commitments and ideals of nursing are to provide care and caring for others (Hawthorne & Yurkovich, 1994; Watson, 1988). Drew (1986) states, "More attention should be given to the emotional needs of caregivers so they in turn will have emotional reserves with which to provide patients with confirming care" (p. 43).

In an era of financial constraints and decreased resources, reduced numbers of Registered Nurses, higher patient acuity, and increased intensity of institutional care, care for the caregiver remains an important issue for both nurses and clients. Morse, Solberg, Neander, Bottorff and Johnson (1990) suggest that support and recognition from colleagues may alleviate personal frustration and maintain a nurse's ability to care. Most

nurses would acknowledge the value of caring for clients; however, caring for colleagues is often overlooked. Clinical observations of nursing personnel have led researchers to question whether nurses feel cared for in today's hospital environment.

Nurses are committed to providing caring to others (Hawthorne & Yurkovich, 1994) but as Gaylin (1976) suggests, caring for others is possible only to the extent that humans feel cared for themselves. Maintaining a caring attitude may be difficult when, as Harrison (1990) maintains, nurses have unrealistically high expectations of themselves and their co-workers. High expectations, when unfulfilled, can lead to feelings of depression, frustration, and anger that can be directed against self and others (Holden, 1991). These feelings may lead to an inability to care for patients. It is possible then, that caring from colleagues may help to alleviate such emotions and support nurses in providing caring to others. Nurses sometimes engage in caring for their patients in settings where they, themselves, are not cared for by their organizational colleagues or by their employers (Reverby, 1987).

Benner (1984) states that "the demands of nursing are large ones. The pains, risks, and dangers encountered are sometimes great and cannot be experienced without personal cost" (p. 208). As well, if one's work is not viewed as important, as is often the case in nursing (Reverby, 1987), nurses may become estranged from one another; this divisiveness can result in helplessness and oppression (Keen, 1991; Roberts, 1983). According to Roberts (1983), it is difficult in nursing practice to be caring for others when one feels oppressed; people who are oppressed often strike out against one another rather than support, value, or care for one another. Furthermore, the need for nurse-to-nurse caring was substantiated by a study conducted by Attridge and Callahan (1990) who examined nurses' perspectives of the quality of their work life. They found that nurses put positive work relationships second only to adequate staffing in importance and concluded that caring among nurses is an aspect of caring in nursing that must be strengthened in order to improve the work life of nurses.

Definition of Caring

The concept of caring is represented widely in the nursing literature, yet there appears to be a diversity of meanings associated with its use; therefore, confusion and misinterpretation are common. Montgomery (1993) asserts that caring is a way of being and a state of natural responsiveness to others. Leininger (1981a, 1981b) defines caring as supportive, or facilitative acts toward another individual or group with evidence of anticipated needs to improve a human condition. Fealy (1995) suggests that "caring is not simply a series of actions, but rather is a way of acting which is both contextually dependent and value bound" (p. 1136). These different perspectives of the concept of caring, from a physical action to a way of being, create confusion as nurses attempt to understand how to facilitate caring.

Purpose of the Study

Noddings (1984) noted that when two human beings care for one another, both individuals benefit. Although caring has been increasingly studied over the past decade, the majority of studies have examined caring in relation to nurse-to-patient interactions. In reviewing the literature for this study, no published studies of caring in nurse-to-nurse relationships were found. Thus, little is known about the importance nurses attach to caring for each other. This lack of knowledge raises a series of questions: Do nurses experience caring from their peers? Under what conditions do nurses care for their peers? How important is it for nurses that they be cared for by their peers? To what extent does feeling cared for help nurses to fulfill their obligations to patients? Accordingly, this study is a preliminary inquiry into the phenomenon of caring between nurses. The goal of this study is to examine nurses' perceptions of whether they feel cared for by their colleagues, to determine whether such caring is important to them, and to describe the behaviours exhibited by other nurses that result in feelings of being cared for. The research question was: "What is the nature of caring that occurs in nurse-to-nurse relationships?".

Method

An exploratory, descriptive design using an ethnographic approach, or study of the culture of nursing, was chosen to investigate the nature of caring experiences shared by nurses. Morse and Field (1995) suggest that an ethnographic approach is appropriate when exploring and describing a phenomenon from an emic, or insider, perspective. Davies (1995) stated that trying to describe professional caring in nursing is like trying to see invisible mending: much of it cannot be seen unless it is identified and clarified by a professional "insider". Kyle (1995) indicates that a qualitative approach is preferred in the investigation of caring since quantitative studies have not been effective in achieving clarity of the concept of caring. As a consequence of this, interviews with nurses were used as the primary method of data collection.

Sample

The sample for this study was purposive, that is to say each nurse interviewed had been identified by a colleague as being a "caring" nurse. Although I had no objective evidence that these nurses were caring, I was willing to trust the assessment of my professional colleagues. Seven Registered Nurses were interviewed. They were female and ranged in age from 30 to 61 years. Each nurse had been employed in rural hospital and community settings from 6 to 40 years. Once each of the nurses had confirmed her willingness to participate and informed consent had been obtained, she was included in the sample. Eligibility to take part in this study included registration as a nurse in the Province of Alberta, and the ability to identify and discuss experiences of caring for, or being cared for by a colleague. Nurse participants were asked to relate a story of at least one interaction they had experienced with a colleague in which they were either the recipient or the provider of caring.

Data Collection

The interviews were conducted between January and July of 1996. Each nurse was interviewed twice in face-to-face interviews; both interviews were audio-taped and

transcribed verbatim and each nurse was assigned a pseudonym to ensure anonymity. Both interviews lasted approximately one to one and a half hours. In the first interview, I used open-ended questions (see Appendix A). Questions for the second interview were generated following the analysis of the initial interviews and were used to clarify, elaborate, and/or confirm data and interpretations. Data were collected until new concepts no longer arose from the data (Spradley, 1979). All interviews were held at a time and place convenient to the participant, outside of work hours, and in a setting that offered privacy and freedom from interruption. I maintained a journal to record my ongoing questions, experiences, insights, and concerns throughout the process of the study. The journal assisted in clarifying my thoughts and influence on the research.

Data Analysis

Data collection and analysis occurred concurrently and were interdependent. Data analysis began with coding the data and labelling related words. During the next phase, themes, patterns, and concepts that were descriptive of caring interactions were grouped into distinct categories. There were 18 categories initially and this was later refined to six categories. The labelling of the categories reflected terms that the informants offered in their interviews.

A process of memoing was also used during the data analysis phase. Memoing was conceptual in intent and was a method of capturing the ideas and interpretations of categories and patterns that were identified during the data analysis (Miles & Huberman, 1984). It allowed me to refine and expand the codes and reach higher levels of critical thinking. By making notes on a copy of the transcript each memo was dated and labelled according to the key concept .

Presentation of Findings

The Essence of Nurse-to-Nurse Caring

Each informant who was identified as a caring nurse stated that she had experienced caring from her nurse colleagues, and that caring was important to her in the

work environment. For example, Carol's comments represented many of the nurses' views when she stated, "I think it [nurse-to-nurse caring] is essential to the success of an individual in a career as a professional [nurse]" (3a, 115-116)*. She continued, "I didn't have the emotional maturity or . . . the life experiences to get through a situation like that without the support from my colleagues" (3a, 188-191). Betty, when asked to define caring stated, "I think it means supporting . . . not necessarily agreeing with everything everybody does or says, but supporting each other whether it [the experience] is good or bad" (2a, 712-715).

In attempting to clarify what nurse-to-nurse caring meant to them, the nurses interviewed used many descriptive words. These descriptive terms included trust, respect, intuition, empathy, reciprocity, sensitivity, tolerance, compassion, sincerity, humour, listening, touch, concern, interest, doing for others, helping, love, interest, sharing, wholesome, warm, non-judgmental, understanding, connecting, and supporting.

Five major elements of nurse-to-nurse caring were identified during data analysis, including: "being there"; "supporting"; "creating a climate"; "valuing the other" and sending that message of value; and "acting as an advocate and mentor" to nurse colleagues. Each of these elements is discussed individually with examples from participant interviews.

Being there. The first element was described simply as "being there". Being there as a physical co-presence includes listening, touching, trusting, smiling, and some kind of signalling or communication to reduce feelings of isolation. When discussing the brief, but important, moments when nurses listen to one another, Gwen stated, "I guess if there's something bothering you, even if it's just a little something and you tell someone else, it usually bothers you less" (7a, 800-802). Debra stated, "It made me realize that sometimes you don't talk. Sometimes you just sit there, hold their hand and listen.

* this quote is from the 3rd participant's first interview, lines 115-116

Sometimes there's nothing to listen to but you're just there" (4a, 363-367). She added, "For me personally, I guess it means that there's somebody there when you need them[sic]" (4a, 716-717).

Touch was clearly an important part of being there. These nurses talked about touch in similar ways. One nurse stated, "As you're sort of flying by you kind of give them [your colleagues] a pat and say 'hang in there. It will be ok' " (Evelyn, 5a, 636-638) Gwen said, "lots of times, one nurse to another, there'd just be a pat on the shoulder or just a hug as you change shifts" (7a, 194-196). Frances stated, "They hugged me and supported me. They didn't care where [we were]" (6a, 258-260). Helen noted, "We did a lot of crying and a lot of hugging" (8a, 322). Evelyn says she gives a thumbs up sign if she believes a colleague needs caring and time-lines are tight in the work environment. Another nurse talked about winking to her colleague as they rushed by one another.

In addition to touch, these nurses said trust was another important component of being there. They suggested in their descriptions of caring, that trust is not only a central component of nurse-to-nurse caring but the nurse-to-nurse caring that does occur appears to increase trust. For example, Carol said:

> For you to put yourself out and care for another nurse can be risky at times . . . . trust is built [when] I know that I can care for you and you can care for me and we have this mutual support network system developed. (3b, 175-182)

These nurses remarked how easily trust develops and how easily it can be eroded. As Carol said:

> I'm sure you've had that experience where you do sense that there's a problem where you try to approach someone . . . and say, "Is this situation bothering you? And then you're rebuffed. Well, the next time you sense that there might be a need, you might not be as eager to offer some help or some support, but if your overtures are received and embraced then I think

> . . . there's that trust [that develops]. That trust that you are important [to your colleagues]. And it makes you feel good. (Carol, 3b, 187-198)

Carol's description of how fragile trust is, is an example of how important it is to these nurses that their need for caring is recognized in a timely manner, and that they are not imposing on their colleagues.

Supporting. In addition to the physical element of "being there", a second important element of nurse-to-nurse caring is supporting. In this study supporting was said to include both an emotional and physical element. Emotional support was experienced during or following both traumatic and positive nursing experiences. Helen stated:

> We don't need to be saying to each other we're here all the time . . . instinctively we know that they [nurses] are there. I've heard people say in support groups that they never feel alone . . . . That's the way it is with nursing too. You know that there's always someone there for you. (8a, 821-829)

Physical support, while important, includes an element of concern for one another. It can include helping to prepare a body for the morgue. Francies stated:

> A patient had died and it wasn't my patient. I also knew how this girl [nurse] felt about dead bodies so we just, one of the other girls and I, just went in and took care of it. But then afterwards we went and talked to her and essentially said that's ok, and tried to get her to maybe talk a little bit about her feelings and what made her have a hard time with it. She recognized it as sort of being a problem and said, "I have to learn to deal with it". After that there would be times when she wouldn't let us take over. She would go in but we would be there with her. (5a, 516-529)

Supporting colleagues is dependent on the existing relationship. As Frances said, "Because we are a support group for one another, almost like a family, we discuss things

like this amongst ourselves" (6a, 197-200). Helen echoed this point when she stated, "We care about each other. We're more like family here than we are just co-workers" (8a, 55-56). The existing relationship or connectedness between nurses is dependent on the history of the relationship, the relationship narrative, shared experiences, and physical proximity. As Carol noted:

> I think we're in a unique position to support each other by virtue of the fact that we work so closely with each other in very, very emotionally-ridden situations . . . . I think that some of what caring means is that you support each other and that you care about each other and that you're there for each other. I really believe that you can't do it on your own. You can't work in isolation. (3a, 123-136)

Helen provided examples of both "being there" and "supporting" when she described nurse-to-nurse caring: "For me, caring is support. It's being there for someone, understanding where they're at, being protective" (8a, 809-811).

Creating a climate. The act of creating a climate is indicative of caring. The term creating a climate includes ideas such as providing privacy or separating the nurse from a stressful experience or from public gaze, providing a positive physical milieu, and providing a positive emotional environment. Some nurses noted that a level of privacy was essential for nurse-to-nurse caring. When discussing when she had cared for an emotional colleague, Debra said, "So, at that point I just closed the door . . . and then we went for coffee away from the place" (4a, 637-639). Gwen talked about experiencing the death of a child: "There were no words spoken. She just took me off to a room and let me have a little cry on her shoulder and gave me a hug" (7a, 226-228). The physical structure of the environment can be important to the caring interaction. When the cared-for-nurse needs privacy or a safe emotional environment, the caring nurse might relocate the interaction to another place so that caring can occur, thereby creating a level of comfort. Some of these nurses described how they created an atmosphere conducive to caring by

hanging pictures and posters, putting flowers in their work areas and sometimes even providing comfort foods.

The idea that a positive emotional climate is important was reinforced when Carol stated, "I think that being open and available and receptive is being caring as well" (3a, 784-786). She added:

> Kind of having an open door and being there for her when she has a need . . . . that each one is important and that their [sic] questions are important . . . that's the difference between someone that you would approach or that you would perceive as caring . . . . It's someone that . . . sees past [other] priorities. (3a, 906-930)

Evelyn described a time in her life when she needed caring due to a personal loss and the caring from friends and family was not enough:

> I know with some of my family for sure, and maybe some of my friends, I still took the role of the nurse and I had to care for them so, I wouldn't . . . let myself fall. [With my colleagues] I felt that . . . I was me. I was the patient and they could look after me. (5a, 294-310)

When she was with her colleagues, she felt she was able to let herself relax and be cared for by them rather than having to maintain a cheerful front.

The importance of the relationship with fellow nurses was frequently mentioned. Helen stated, "You're more than colleagues, you're everything" (8a, 499-500). These nurses felt that creating a positive climate yields support and caring.

Valuing the other. The third element of nurse-to-nurse caring that emerged from the data is "valuing the other" and sending that message of value every time nurses interact. Valuing the other is linked to supporting as each member of the duo holds the other in high regard and communicates that value. Debra stated:

> You can feel like you can be vulnerable and fragile and not get hurt more than you already are . . . feel accepted no matter what, even if you're not measuring up to where you think you should be. I guess just accepted as a

> human with all the frailties that goes with that. And sometimes it means that those people can help you get through that mist or fog that you find yourself in. So, you can be a little more objective. They help you move along, but they don't push. They sort of cradle you. (4a, 718-728)

These caring nurses believe that determining and valuing what each nurse needs is a part of nurse-to-nurse caring. They believe that choosing an appropriate expression of caring is a way of demonstrating respect or value for the cared-for-nurse. Some nurses in need of caring might need touch to feel cared for; other nurses might value a smile. When she was discussing how one determines the kind of caring needed, Gwen stated, "I don't mean cues that somebody needed support. I mean cues that they were comfortable with a hug or the caring . . . with the touching . . . as opposed to maybe somebody just patting their back or being more informal" (7a, 478-483).

Mentoring. The last element of nurse-to-nurse caring is "mentoring". Mentoring is different from support because it implies a longer term involvement or interaction between an experienced nurse and a less experienced nurse rather than moments of intimacy. Mentoring can be advocating for the other, acting as a role model, or supporting the less experienced nurse through upsetting experiences. Carol noted that although nurse-to-nurse mentoring has not traditionally been seen as important, having experienced a mentoring relationship as a beginning nurse meant a great difference to her nursing career and her professional outlook. In discussing a painful and disturbing death of a client with AIDS, she said:

> We discussed that a lot. She [the mentor] gave me a lot of strength to kind of come out of that situation with a positive outlook on death and on that transition and on the passage of people. I think it could have been a really traumatic incident for me that would have impacted my whole perspective on death and dying and palliative care had she not really, kind of, debriefed me about how he did die and what good had happened through the whole process and how things

> ended. And the good that we had done to support him and the family. I just look back on that and can never appreciate enough the support that she made a point of giving me. That, I think, if I hadn't had it or had been in the situation with maybe a different person, I would have come out of that with a really different perspective . . . that would have impacted my nursing for the rest of my life, really. (3a, 415-432)

Carol added:

> I think this person has been a really good advocate for myself and in different situations put my name forward for different committees and different responsibilities . . . Support as a nursing professional that has been really appreciated. (3a, 626-633)

Each of these five elements (being there, supporting, creating a climate, valuing the other and sending that message of value, and mentoring) were described by several of these caring nurses as the foundation of nurse-to-nurse caring. In addition to the five elements of nurse-to-nurse caring, these nurses described ways to facilitate the nurse-to-nurse caring that occurs among colleagues.

Facilitating Nurse-to-Nurse Caring.

These nurses were asked what, in their experience, facilitated collegial caring. They indicated that there were a number of components necessary for nurse-to-nurse caring to occur. The first was that nurses had to be motivated.

Motivation to be caring. The first component of facilitation is a "motivation to be caring" to colleagues. This motivation comes from past positive relationships or shared experiences. Carol believes that caring is stimulated or motivated by talking, by sharing feelings, by relying on the other, and by making a point to care. Some of these nurses talked about the notion that people go into nursing because of a desire, or need, to be caring. Helen stated that a person who goes into nursing is a special type of person; a person who is inclined to care for others and to benefit from the human contact.

Belief in self as a caring person. The second component that facilitates nurse-to-nurse caring is "a belief in self as a caring person". The majority of nurses interviewed believe that they are caring people and are caring to their colleagues. As one of them said:

> I like to think I am [a caring nurse]. I really don't think I stand out from any of the girls I work with because all of them are very caring people. In this office particularly we have been very supportive of each other. (Helen, 8a, 38-42)

Helen stated, "It's hard to say why you care . . . for your colleagues. I think there is something innate, something like your soul that is hard to put a handle on" (8a, 668-670).

Confidence and energy. The third component that facilitates nurse-to-nurse caring is "having and maintaining the confidence and the energy to be caring". Carol stated, "the more self confidence that you have and maybe the more you're cared for, the more you care for people, the more you have to give, to spread around" (3a, 636-639). It was maintained by many of these caring nurses that the act of nursing and caring for patients uses energy and frequently depletes one's confidence. Carol talked about a lack of sensitivity due to work stress and self-absorption as a beginning nurse: "I think when you're a new grad, you're so into running around just taking care of yourself and getting through your shift that you don't have any other time to think about anyone else's needs " (3b, 448-451).

Knowledge The fourth condition that facilitates nurse-to-nurse caring is "a knowledge of nurse-to-nurse caring". The majority of these caring nurses believe knowledge is based on education, role modelling, and past experiences of caring. Carol stated that, "sensing when someone needs to be cared for and how to care for that person is more developed with life experiences and nursing experiences as well" (3b, 443-446). These nurses believed that being educated to care for patients assists in the development of nurse-to-nurse caring knowledge. Many of these caring nurses expressed the belief that through education and nursing experiences nurses learn to assess patients and determine

what kind of caring they need, and that knowledge can be transferred to nurse-to-nurse caring situations. Carol stated:

> Having gone into the nursing profession has made me more sensitive to the impact you have on people around you . . . . You get feedback from your education and your socialization as a nurse that makes you more in tune as a caring person. (3a, 41-50)

She continued, "as nurses, it [caring] is a characteristic we cultivate" (3a, 320-321).

Blocks to Nurse-to-Nurse Caring

Many of the nurses interviewed also talked about what blocked nurse-to-nurse caring. They stated that lack of trust of, or lack of respect for, a colleague hinders nurse-to-nurse caring as does a lack of positive relationships. In addition, a shortage of time, other commitments, guilt, and a focus on self blocks nurse-to-nurse caring. Carol talked about commitments by stating, "The needs of your patients come first and would override a particular need that a colleague might have" (3a, 865-868). When discussing a focus on self, Frances stated, "If they [nurses] don't receive caring . . . I don't think they can give it . . . . I think if you're hurting, you have more of a tendency to turn your thoughts on yourself than towards others" (6a, 338-346). A few of the caring nurses suggested that sometimes a focus on self, or self-caring, can be a very positive thing because nurses have to protect themselves. They also stated that a feeling of vulnerability, a lack of energy, a lack of sensitivity to others, and a knowledge deficit in how, why, and when to care blocks nurse-to-nurse caring. Debra described feeling vulnerable and her responses to that vulnerability: "When I feel really vulnerable I have a hard time caring for others. I end up having to pull back and re-group . . . . My colleagues are probably not getting what I normally give" (4a, 790-798). These blocks to nurse-to-nurse caring were perceived by many of the nurses interviewed to influence future caring relationships among nurses. In addition, these blocks to nurse-to-nurse caring also determined nurse-to-patient relationships even though these relationships are believed to be dissimilar by

the nurses in this study.

Nurse-to-Nurse Caring Versus Nurse-to-Patient Caring

Not only did these nurses describe what nurse-to-nurse caring was, they differentiated it from caring for patients. Carol stated, "There's certainly a different nature inherent in a nurse-to-patient relationship . . . . You're not necessarily on the same level . . . You're still the nurse and they will always be the patient, or the client" (3a, 717-721). When describing how nurse-to-nurse caring can be based on friendship and/or a working relationship, Carol stated, "The difference is that we're often friends with our colleagues" (3a, 712-713), that "the nature of caring between colleagues is more spontaneous . . . it's not as expected" (3a, 764-765). These nurses believe nurse-to-nurse caring is based on a more equal or level relationship. "It [nurse-to-nurse caring] is also based on a friendship and [an existing] relationship (Carol, 3a, 740-741).

The caring roles, however, can change in nurse-to-nurse caring. Many of these nurses described how during one incident of nurse-to-nurse caring, the nurse can be the one doing the caring, and during the next incident, she could be the recipient of the caring. Nurse-to-patient roles are more proscribed; a nurse is usually the one doing the caring and the patient is usually the one receiving the caring. In addition, a nurse doesn't expect caring back from the patient, although patient-to-nurse caring does occur. As Carol said, " I think the caring you exhibit for a patient is unconditional. You are certainly more able and determined to keep that sense of professionalism inherent in your interactions with the patient" (3a, 723-727). She later added: "You can care for someone in a nurse-to-patient role that you might not necessarily like, or want to be friends with, and still have an element of caring in that relationship" (3b, 47-52). All nurses in the study believed nurse-to-patient caring was part of the professional role.

Many of the interviewees said that although nurse-to-nurse caring was not anticipated, it can be reciprocal. They suggested that to develop the level of empathy necessary for nurses to establish caring relationships, it is helpful to have similar background experiences from which you can draw. Gwen stated, "It made me feel very

comfortable to know . . . even without saying . . . that somebody understood what I was probably going through" (7a, 277-281). Nurses share work experiences that contain emotional highs and lows and many poignant issues.

Impact of Nurse-to-Nurse Caring

According to all of the nurses interviewed, nurse-to-nurse caring creates a positive impact and a sense of well-being for both the nurse caring and the nurse being cared for. Caring from nurse colleagues makes nurses feel appreciated and loved. Carol related a story about the time that her cat was run over:

> I got to work and this friend of mine, a nurse, came in and said "What's the matter with you?" And I said "My cat got run over" and I just burst into tears. I felt so dumb just because of all the things that you deal with in your life that should be so minor. And of course she was so supportive . . . . She wasn't a big cat person. But it really helped. And I don't think you get that anywhere else . . . I just think that's a funny example because of all the situations that we deal with as nurses, to bring something like that to the table and still get what you need when you need it . . . that my messages were received. This was really important to me and was a very, very sad time for me . . . and people picked it up. It didn't matter that it wasn't a major catastrophe. (3b, 675-696)

There was a really strong emotional response when these seven nurses recalled, or retold, critical caring events, whether or not the events had occurred as recently as the day before or as long as 25 or 30 years ago. The majority of nurses interviewed cried, or became emotional, when relating their caring experiences. The fact that many of the participants were tearful as they told their stories suggests that receiving caring from a colleague resulted in a deeply felt emotion, and was significant and important, even years later. Comments that illustrated the importance of receiving collegial caring included Helen's despair in dealing with the many deaths in the palliative care program: "I'm sure I'd have an nervous breakdown. I couldn't do what I do without the support of my

colleagues" (8a, 424-425). These nurses tended to use the terms "support" and "caring" interchangeably, which indicated how closely these terms are equated. Carol recalls dealing with her first death as a new graduate: "There's no way without it [nurse-to-nurse caring]. I didn't have the emotional maturity, or the life maturity, to get through a situation like that without support from my colleagues" (3a, 188-191). She had previously stated, "I don't know necessarily whether I would have persevered in nursing if I didn't have the support of my colleagues. I really believe that" (3a, 154-156). Gwen reinforced this view when she stated, "I think it [nurse-to-nurse caring] allows you to keep going back to work because you know that somebody understands" (7a, 314-316).

Although all of these nurses valued the support and caring of their colleagues very highly, they tended to discount the value of the caring they gave others. They perceived the actual caring they gave to their colleagues as incidental or of minor importance. This is demonstrated by Carol, who said:

> When I think of all the incidents where people have supported me, I think of these great big major life events, and when I think of when I have [provided caring], it's maybe something that isn't quite as earth-shattering. It makes you wonder . . . what your perceptions of caring are, how they differ from others that you interact with, whether they would identify with the situation [the same way] you would. (3a, 666-674)

This difference in perception is also echoed in the comments of others. "It [caring] doesn't seem as much as what Doreen did for me" (Debra, 4a, 628-629). "Except for being there for them emotionally and physically . . . I can't think of events really where I was much support to anybody" (Frances, 6a, 409-410). When nurses who were recipients of caring were asked if they told the nurse who cared for them how much the caring meant to them, usually they assumed that she knew that it meant a lot to them, however, they did not tell them directly. Gwen related an emotional event where she received caring from a colleague after the death of a child; she stated, "I mean she knew that it

helped . . . but we've never referred to it again really" (7a, 329-331). This discrepancy between the deeply felt emotion and importance placed on the caring received, and the diminishment of the caring provided to others, identifies the need to remind nurses, from time to time, of the importance of collegial caring.

Another outcome of nurse-to-nurse caring is the ability to be more aware, open, or sensitive to opportunities for future caring. "It [nurse-to-nurse caring] probably allowed me to open up within myself" (Gwen, 7a, 295-303). Evelyn stated, "It [nurse-to-nurse caring] makes you a little more open-minded sometimes" (5a, 545-546). She added, "after you've blocked things off for too long or too deep . . . you stop feeling and you stop recognizing what other people are feeling too" (5a, 568-570). A few of the nurses interviewed believed that they would become increasingly numb and unresponsive to both patients and other caregivers if they didn't deal with the emotions that were going on inside them as a result of their nursing experiences.

The data collected suggest that nurse-to-nurse caring rebuilds energy and self-confidence. It leads to an ability to continue to care for patients and for other nurses. Evelyn commented, "if nobody had helped me . . . you [sic] could have coped but I think you [sic] would have put a lot of energy into . . . hiding your [sic] emotions" (5a, 568-574). All of the nurses interviewed believe that nurse-to-nurse caring leads to a better work environment. Evelyn stated, "I think it makes your work environment easier" (5a, 86-87). Carol supported this view when she went on to describe the results of nurse-to-nurse caring: "I think it [caring] is essential to the success of an individual in a career as a professional [nurse] (3a, 115-116).

Nurse-to-nurse caring provides nurses with the ability and the strength to relate to other people and to deal with difficult situations. Evelyn stated that even though she still talks to her family about situations that occur in the work place, her husband and children don't understand because they've never been there. She believes that sharing with a colleague reduces feelings of isolation: "You don't feel so alone" (5a, 86-88). Nurse-to-

nurse caring provided relief for the nurse sharing her feelings. It was described as a lightening of the load because these nurses are able to share experiences with people who really understand since many have experienced similar events.

There was the perception by many of the interviewees that changes and challenges in health care today increase nurse stresses and, therefore, increased nurse-to-nurse caring is needed. Debra stated, "Anybody working in health care right now needs to be nurtured and cared for" (4a, 924-926). Some of the nurses interviewed also mentioned the stresses that nurses experience and stated that nurse-to-nurse caring can result in nurses remaining in the profession since they believe collegial caring prevents burnout. "If we don't support each other I think that you're not able to continue and effectively deal with the stress of the situation that nurses are in" (Carol, 3a, 127-130).

The Process of Nurse-to-Nurse Caring

Nurse-to-nurse caring was described by all of these nurses as a process. Although manifested in different ways, this process was a consistent attribute of all nurse-to-nurse interactions. The process starts when the person in need of caring sends out some kind of signal or cue. These nurses described behaviours, such as crying or being upset, having a blank face or a vacant look, unaccustomed silence, and/or making changes in body posture, as signals seen in colleagues in need of caring.

The process continues when a nurse who is sensitive or open to the cue given intercepts and understands the signal. Picking up the cue is facilitated when nurses know their colleagues well and the existing relationship is strong. Gwen stated, "She [the caring nurse] knew immediately that I would need some support . . . . I think she just looked at my face and knew I was in pain. It was unspoken. We didn't have to say anything to each other" (7a 218-249). Many of these caring nurses stated that when they were overworked, stressed, or protecting themselves in some way, they tended to be less sensitive to the cues sent by their colleagues.

The next step of the process occurs when the nurse who received the signal for

caring demonstrates sensitivity to the kind of caring required. Will she respond by 'being there", "by touch", "by valuing the other" or by "supporting" her colleagues, or by "acting as an advocate or mentor"? Not only does the nurse who will initiate the caring have to receive and be sensitive to the cue, she also has to think about the kind and appropriateness of the caring she is going to engage in with her colleagues. Finally, the nurse providing the caring has to initiate, and carry out, the caring act. Carrying out the caring act depends on the desire, knowledge, and skill of the nurse.

Discussion

The purpose of this study was to analyze the nature of caring in nurse-to-nurse relationships. Nurses interviewed said that they do experience caring from their peers and this caring is important to them and to their nursing careers. The definition of caring remains ambiguous. The diversity of meanings in the literature is reflected in the manner these nurses describe nurse-to-nurse caring. A few of the nurses referred to the actions of nurse-to-nurse caring, while other nurses referred to the manner in which their colleagues carry out actions or to their colleague's "way of being". Many of the nurses interviewed used the terms caring and support interchangeably. This reinforces O'Berle and Davies' (1992) comments that there is an overlap that exists between the concepts of caring and support. These nurses believe that the feeling of being cared for by their colleagues helps them to fulfill their obligations to their patients by providing them with energy and confidence to continue to care for patients in environments which tend to deplete those attributes.

During the course of the study, the nurses described the behaviours and ways of being that were exhibited by other nurses that resulted in feelings of being cared for. Many of the factors identified in this study of nurse-to-nurse caring interactions have been alluded to in studies of nurse-to-patient caring interactions. Nurses described the differences between nurse-to-nurse caring and nurse-to-patient caring based on the nature of the relationship and the consolidation of roles. Several of the nurses in this study

described the importance of creating an open and receptive climate that could facilitate nurse-to-nurse caring and the importance of valuing the other and sending that message of value to their colleagues. This is similar to the views expressed by Drew (1986), who emphasizes the need for openness, Paternoster (1988) who values the willing acceptance of responsibility of the relationship, Fry (1988) and Gadow (1989) who deal with the ethics of caring, and Dyson (1996) and Morrison (1991) who describe the importance of being motivated to care.

These nurses discussed the importance of values and beliefs that reflected the respect and trust that nurses have for one another and which facilitate nurse-to-nurse caring. Similar ideals and values serve as a basis for nurse-to-patient caring and are referred to by Fry (1988, 1989), Gadow (1989), Gaut (1986), and Morrison (1991). Cronin and Harrison (1988) described how patients who had suffered a myocardial infarct evaluated effective nurse caring, stating that the presence of the nurses who made it clear the patients' concerns were valued made the patients feel somebody was there if they needed them. This statement reflects the description of the nurses in this study when they stated that nurse-to-nurse caring results in reduced feelings of isolation.

The words used to describe caring by the nurses in this study reflect Watson's (1979) caring behaviours which are based on relationships characterized by trust, hope, sensitivity, empathy, touch, warmth, and genuineness. These nurses continually used descriptions of supportive activities to describe caring, while Watson (1979) refers to caring activities of support. The nurses interviewed in this study described how listening was an important part of "being there" for colleagues. Similarly, Wolf (1986), in her examination of literature from nursing and other disciplines dealing with the concept of care, selected words and phrases from the literature that represented caring and then ranked them. Attentive listening was the highest ranked phrase that demonstrated caring. The emphasis given to touch by these caring nurses substantiated Bottorff's (1991) discussion of the importance of touch to patient caring.

Nurses in the study highlighted the importance of being sensitive to the type of caring needed by colleagues; this perspective could not be located in the literature. Dyson (1996) discussed consideration and sensitivity in terms of being understanding and kind, but did not relate this sensitivity to the type of caring provided. What was intriguing and not discussed in the literature was that, although nurses perceived that the nurse caring they received was meaningful to them, they did not indicate this to the nurse providing the caring. It may be that they believed the importance was intuitively recognized by the nurse providing the care. Perhaps this lack of positive response is due to the fact that nurses are taught it is their duty and responsibility to care for patients without necessarily receiving feedback. In addition, nurses discounted the value of their caring for other nurses. This could be because the importance of their collegial caring is rarely affirmed by nurse colleagues.

The nurses interviewed stated that nurse-to-nurse caring creates a sense of well-being and enhances nursing practice and nurse-to-patient caring. These nurses described a process; one that occurs when nurse-to-nurse caring interactions take place, which is consistent with Gaut's (1986) belief of caring as a process of action.

The nurses who took part in this study believe that their ability to provide caring has been enhanced by their increased knowledge as a result of nursing education and their nursing experiences, but obtaining education and experience increases stressors and the need for caring from their colleagues. The literature supports the premise that nurses face increasing demands for improved education; broader, yet detailed, knowledge and increased efficiency and speed in environments with growing workloads and inflexible work situations. This is further compounded by reduced numbers of Registered Nurses, increased demands of critically ill patients, and a hostile environment that does not value the caring that nurses believe will enhance the lives of their patients. Nurses who continue to provide nurse-to-nurse caring in this environment demonstrate the value and importance nurses attach to human caring.

Conclusion

Nurses in this study claimed that nurse-to-nurse caring does occur at work and that it enhances their nursing practice, providing them with the confidence and energy to care for others. It is therefore, surprising that little has been written on about nurse-to-nurse caring. Moreover, these caring nurses believed they were inhibited by the structure and environment in which they worked, which suggests that if they do not receive care themselves, they may find it difficult to achieve and maintain the energy to care for patients in a productive manner.

Evidence from this limited study suggests that if a nurse understands the process of nurse-to-nurse caring it allows her to recognize when caring is needed to achieve and maintain a sense of well-being for nurses and assists nurses in their goal of providing caring to others. If nurses do value caring, they need to remind themselves to be sensitive and open to the cues, or signals, that colleagues send out when they need caring. Collegial caring is a deeply felt experience for the recipient and often the nurse providing the caring is not aware of the impact she has on the lives of colleagues when making a decision to care for them. Nurses could acknowledge the caring that occurs and be open when describing the effects that the caring has had on them.

Although the findings of this study provide insight into the quality of nurses' working lives and the quality of caring between them, it is possible other nurses might share different caring characteristics depending on their particular situations, work environments, and the availability of health care resources. An opportunity to observe nurses caring for nurses in their work environment might have thrown more light on the nature of nurse-to-nurse caring, and so the lack of direct observation should be considered a limitation of this study. It is recommended that future research in this area include participant observation of nurses interacting at work.

The findings have done nothing to clarify the confusion of the term caring and indeed support and caring were frequently used synonymously by the nurses interviewed

in this study. These nurses, when describing nurse caring as a process, reflected the view offered by Fealy (1995) that caring is a series of actions dependent on context and values.

Finally, nurses are highly sensitive to cues from colleagues as a result of their education and experience as nurses caring for patients. Although findings from this study are limited, it is clear that nurse-to-nurse caring is valued by nurses. Utilizing information from this study and other caring research to teach nurses about nurse-to-nurse caring may improve the quality of caring between nurses and the quality of nurses' working lives.

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Appendix A

Guiding Questions

1. You have been named by a colleague as a caring nurse. Do you acknowledge that you are a caring nurse? What is it about you that makes you a caring nurse?
2. Tell me what caring between nurses means to you.
3. Can you describe why it is important to you that nurses care for one another?
4. How would you describe an event that occurred with a colleague in which you were the recipient of a caring interaction?
   - In what environment did the caring event occur?
   - What was happening when the caring occurred?
   - What did your colleague do that made you feel she/he was caring?
   - What were your feelings during the interaction?
   - What were your feelings following the interaction?
   - How were you better able to care for your patients following the caring?
   - What initiated the caring behaviour?
   - Tell me about other times when a colleague was caring towards you.
5. Describe an event when you felt that you were caring towards a colleague.
   - What caused you to initiate the caring interaction?
   - What was happening around you when you began caring for your colleague?
   - What were your feelings during the interaction?
   - What were your feelings following the interaction?
   - Are there other times when you felt you were caring towards a colleague?
6. What does caring mean to you in a collegial relationship?

Postscript

Because of the format of this thesis, detailed descriptions of the method are omitted. The purpose of the postscript is to reflect on the method used.

Method

A qualitative exploratory design was used to investigate the nature of caring in nurse-to-nurse relationships. Some of the interviews were rich with descriptive information while others lacked focus and participants discussed caring interactions that had occurred with health care workers other than nurses. The inclusion of observations of nurses interacting with other nurses in the work site would have enhanced the study.

Sample

Using professional networks, I approached nurses, either in person or by telephone, and asked each to identify a nurse they perceived to be a caring individual. Permission was obtained to use the name of the nominator when contacting the nurse that he or she had identified. A letter (Appendix A) was then sent to the nominees inviting them to take part in the study and stating that they had been identified as a caring nurse by a colleague. The introductory letter contained descriptions of the study, a brief researcher background history, the purpose of the study, the research plan, a response form (Appendix B) and a stamped, self-addressed envelope for the participant to return. The interested participants then mailed the response form to me either to volunteer for the study or to request further information. I telephoned all persons who returned the form to answer questions, obtain verbal consent to participate, and arrange a mutually convenient time and place for the first interview. In retrospect, a letter from the nominators stating why they perceived this nurse as caring would have provided additional valuable information in determining if these nurses were indeed caring, and further insight on the nature of their caring.

The sample size was determined by the data collected (Spradley, 1979). When the description was rich and complete and no new concepts were forthcoming the data

collection ended. According to Morse (1991) the number of instances of information rather than the number of informants is critical in determining sufficient sample size.

Data Collection

Two face-to-face interviews with each participant were held to obtain data. All interviews were at a time and place convenient to the participant, outside work hours, and in a setting that offered privacy and freedom from interruption. A biographical data sheet (Appendix C) was completed to provide information for the description of the nurse participants.

The use of guiding questions facilitated an in-depth description of each nurse's perception of caring. Full exploration of the phenomenon being studied was enhanced by the flexibility of the guided interactive interviews. The guiding questions focused on the nature of caring that occurs in nurse-to-nurse relationships. Each face-to-face interview was planned for one to one and a half hours, with some time at the beginning of the interview to establish rapport and reiterate the purpose of the study. Second interviews occurred approximately five to six months following the initial interview to clarify and validate the data and were also one to one and a half hours in length. Arrangements for these subsequent interviews were made following the transcribing and reviewing of the tapes from the first interviews. A few additional interviews were required for clarification of data and were conducted by telephone after agreement between the researcher and the participant.

Field notes were maintained as an added source of data. A condensed account, an expanded account, and a field work journal were kept. Condensed accounts included single words, phrases, and unconnected sentences. The condensed account was valuable as it was recorded during the actual interview. The expanded account was a broader description of the condensed account and included added details. Complete expanded accounts included the tape-recorded interviews, when they were fully transcribed. I maintained a journal to record ongoing questions, experiences, insights, and concerns

throughout the process of the study. Notes of analysis and interpretation of cultural meanings assisted in formulating an audit trail.

Data Analysis

Sample selection, data collection, and data analysis occurred concurrently and were interdependent. Data analysis included transcribing the data and coding the data by labelling related words, themes, patterns, and concepts that were descriptive of caring interactions. Accuracy of the transcription was vital.

I examined the data for patterns of thought and patterns of behaviour of the participants who had experienced nurse caring interactions. As the data analysis and coding progressed, similar concepts or themes were grouped together or categorized.

I chose to analyze the study by a cut and paste method rather than using the computer. This allowed me to clearly understand the process and to become immersed in the data. Four copies of each transcript were made. The transcripts of each participant were assigned a colour to easily identify the participant during coding. One transcript of each informant's interview, the field notes, and my journal were collected in a binder for referencing. This information was kept in a locked filing cabinet. Themes, patterns, and concepts were grouped into separate categories by cutting up the transcripts and placing each category into a separate box according to the labels which reflected terms that the informants had offered in their discussions. This method of analysis was useful, but now that I understand the process of analysis I would choose to use the computer during subsequent studies. The most descriptive exemplars of the sample selection were chosen to illustrate the findings.

Reliability and Validity

In qualitative research, the procedures for enhancing reliability and validity are determined by the particular research method used (Field & Morse, 1985). Sandelowski (1986) states that the criteria for reliability of the investigator are met by a clear audit trail. Auditability was addressed by consultation with my thesis advisor throughout the

study and careful documentation of field notes. The second interview was another approach to verifying with the participants, meanings and concepts that emerged from the data. Validity refers to the degree to which the research findings represent reality (Field & Morse, 1985). Internal validity refers to the extent that the researchers are actually observing what they believe they are observing. A purposeful selection of informants, audio taping of the interviews, and validation and clarification of the data, interpretation, and conclusions with informants during multiple interviews and after completion of the data analysis enhanced the credibility (validity). The use of guided interviews allowed me to explore the informants' perspective of each caring interaction. The thesis advisor listened to the first audio taped interview and provided feedback regarding interviewing skills and guiding questions. The thesis advisor also examined the process of coding.

Sandelowski (1986) offers fittingness as a method of assessing internal validity. Fittingness is achieved when the findings from a study fit into experiences in other settings, and the reader recognizes the findings as meaningful and applicable to their own experience. Two individuals who met the criteria for inclusion in the study but who were not part of the sample were asked to review the results of the study for fittingness. In addition, during the second interview, all informants recognized findings from the analysis of the first interview as meaningful and applicable to their own experience.

Ethical Considerations

The Faculty of Nursing Ethics Review Committee at the University of Alberta provided ethical clearance prior to the beginning of the study. Nurses from a variety of rural hospital and community settings in central Alberta, who were perceived as caring by nursing colleagues, and who were identified as participating in caring interactions with cohorts, were approached. A written informed consent was obtained (Appendix D) at the beginning of the first interview. Participants were free to withdraw from the study at any time, without consequence; however none did. The consent form indicates that the findings of the study are available to all participants.

Protection of the informants' identities was maintained by the following procedures: (a) The taped and transcribed interviews are kept in a locked filing cabinet and identified by code number only. They will be held in a secure place for a minimum of seven years following completion of this report in accordance with the University of Alberta policy. (b) The transcriptions do not contain any names or data that could lead to the identification of the participants. (c) If the data are required for secondary analysis or teaching purposes in the form of exerpts, anonymity will be maintained.

Personnel

I handled all components of the research study except the transcription of the taped interviews. A secretary transcribed the taped interviews word for word and numbered each line of transcript.

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APPENDIX A

Letter to Participants

Participant _____

Address _____

Dear _____,

This letter is an invitation to take part in a study about caring among nurses. You have been identified as a caring nurse by a nursing colleague [name if permission is obtained]. While caring has been studied increasingly over the past decade, the majority of studies examined nurse-to-patient caring interactions or human-to-human caring interactions. My topic is about caring in nurse-to-nurse relationships.

Should you decide to take part in the study I will arrange to interview you at a time and place convenient to you. During the first interview I will ask you to talk about the caring that you have experienced in interactions with nurse colleagues. During the second interview I will make sure I have interpreted your comments accurately and I may raise new questions. I would like to tape-record the interviews as taping is necessary to do valid and accurate analysis but I assure you that your responses will be strictly confidential and anonymity will be maintained.

I will ask you to sign a consent form. Your participation in this study is voluntary; you are free to refuse to answer any of the questions and to withdraw from the study at any time by simply telling me. I will be pleased to share my results with you when the study is completed.

If you have any questions please call me collect at 1-403-347-5658.

I am a nurse who has returned to university to further my education. This research is part of the requirement for a Master's degree in nursing. I hope you will consider being part of the study. I have included a stamped, self-addressed envelope for your convenience.

Thanking you in advance for your time and consideration. I look forward to hearing from you.

Sincerely,

Linda MacKay, Master's Candidate, Faculty of Nursing, University of Alberta
Box 5005, Red Deer, Alberta T4N 5H5 Phone: 347-5658

Appendix B

Response Form

Project Title:	The Nature of Caring in Nurse-to-Nurse Relationships
Researcher:	Linda MacKay RN, BScN Phone: 347-5658
Thesis Supervisor:	Judith Hibberd RN, PhD Phone: 1-403-492-6399

_____ I am interested in participating in your research study.

_____ I am interested in obtaining more information about your research study.

Name _____

Phone Number _____

APPENDIX C

Biographical Data Sheet

Project Title: The Nature of Caring in Nurse-to-Nurse Relationships

Researcher: Linda MacKay RN, BScN Phone: 347-5658

Date: _____

Age: _____

Sex: _____

Number of years nursing: _____

Number of years nursing in this unit: _____

Level of Education:

RN _____

BN _____

BScN _____

MN _____

PhD _____

Number of children: 0. __ 1.__ 2.__ 3. __ 4. __ >4. ___

APPENDIX D
Consent Form

RESEARCH TITLE: The Nature of Caring in Nurse-to-Nurse Relationships
INVESTIGATOR: Linda MacKay RN, BScN Phone: 1-403-347-5658
THESIS SUPERVISOR: Judith Hibberd RN, PhD Phone: 1-403-492-6399

PURPOSE: The purpose of this study is to develop an understanding of the caring that occurs in nurse-to-nurse relationships. The focus is on your experience with caring in collegial interactions.

PROCEDURE: Your participation in this study will involve the following:
- Two face-to-face interviews, one to ask you to talk about caring, and the second to make sure I have interpreted you correctly.
- Both interviews will be in-person and at a time and place convenient for you.
- All interviews will be tape-recorded by the researcher.

PARTICIPATION: There will be no harm to you if you participate in this research/study, nor will you benefit directly from this study. Results from this study may help nurses to realize that nurses both give and receive care from each other, that collegial caring is important to nurses, and to what extent this feeling of being cared for helps nurses fulfill their obligations to patients.
You do not have to be in this research/study if you do not wish to be. If you decide to be in the research/study, you may drop out at any time by telling the researcher. You do not have to answer any questions or discuss any subject in the interview if you do not want to.
Your name will not appear in this research/study. Only a code number will appear on any forms or question sheets. The researcher will erase your name and any other identifying material from the transcription of the tapes. All tapes, transcriptions, and notes will be locked in a cabinet separate from consent forms or code list for seven years after completion of the research/study. Consent forms will be kept for at least five years. Data may be used for another research/study in the future, if the researcher receives approval from the appropriate ethics review committee.
The information and findings of this research/study may be published or presented at conferences, but your name or any material that may identify you will not be used. If you have questions or concerns about this research/study at any time, you can call the researcher at the number above.

CONSENT: I acknowledge that the above research procedures have been described. Any questions have been answered to my satisfaction. In addition, I know that I may contact the person named below, if I have further questions whether now or in the future. I have been informed of the alternatives to participating in this research/study. I understand the possible benefits of joining the research/study, as well as the possible risks and discomforts. I have been assured that records relating to this study will be kept confidential. I understand that I am free to drop out at any time. I understand that if any knowledge from the research/study becomes available that could influence my decision to continue in this research/study, I will be informed promptly. I have been given a copy of this form to keep.

_____ _____
(Signature of Participant) (Date)

_____ _____
(Signature of Researcher) (Date)

REQUEST FOR SUMMARY:
If you wish to receive a summary of the study when it is finished, please complete the following:

Name: _____

Address: _____

_____